

**Statement by Dr. Paul Nunn
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26 April 2005

**Before the House International Relations Subcommittee on Africa,
International Operations and Human Rights
U.S. House of Representatives**

Chairman Smith, Ranking Member Payne and esteemed members of the Subcommittee,

On behalf of the World Health Organization, I thank you for the opportunity to brief you and the committee today and share our strategy for fighting the global TB epidemic. WHO has been at the forefront of the movement to control TB through the promotion of an effective TB treatment strategy, a single global plan, a single global monitoring and evaluation system (that reports each year to WHO), and a single, coordinated partnership. This Stop TB Partnership, hosted in WHO, is now an effective global movement of more than 300 partners pledged to accelerate social and political action to stop the spread of TB around the world. The US Government has made a major contribution to this partnership, especially through the highly valued work of the Centers for Disease Control and Prevention and the US Agency for International Development.

The global TB epidemic represents an enormous amount of human suffering, pain and grief. About nine million people around the world fall sick with tuberculosis (TB) every year and each year, two million lives are claimed by TB. The stigma attached to TB has serious psychological and social consequences. TB is inextricably linked to the HIV epidemic as TB is the major opportunistic infection and leading cause of death for people with AIDS.

The good news is that TB is treatable with drugs that cost about \$10 for a six month course. With proper treatment, over 90% of cases are curable using the WHO-recommended treatment strategy, known as DOTS. Many countries have made a serious political commitment to implementing effective TB treatment strategies and have made steady progress in scaling up TB treatment programs. Between 1995 and 2003, 17 million TB patients were treated under the DOTS strategy with full engagement and commitment of Ministries of Health in 182 (out of 210) countries of the world¹¹. There has been significant improvement in the quality of detection, tracking, and reporting of TB cases globally in recent years, particularly in the Asia region. Both China and India have shown how DOTS can be rapidly scaled up and in 2003 notified nearly 1.7 million cases between them.

The Global TB Drug Facility, created in the year 2000 is a new mechanism for procuring high-quality, yet low-cost TB drugs for low-income countries. In four years alone, the GDF has provided TB drug supplies to over four million TB patients.

As a result of all these, and other, efforts, in five of six continents, the number of new TB cases is either falling or stable, and the Millennium Development Goals for TB (halving of the prevalence and mortality by 2015 compared to 1990) are likely to be met. Unfortunately, Africa is the one continent where TB rates are rising, sufficiently to cause an increase in global rates. WHO estimates that 2.3 million cases of TB occur annually in Africa, which reports 24% of the total notifications worldwide in a region with only 11% of the world's population. Of the 22 "high TB burden" countries which together constitute 80% of the global TB burden, nine are in Africa. They are DR Congo, Ethiopia, Kenya, Mozambique, Nigeria, South Africa, Tanzania, Uganda, and Zimbabwe. Of these, only South Africa has reached the World Health Assembly's TB control target for case detection. And none of these countries has reached the second TB control target of 85% treatment success. Globally both prevalence and mortality are falling, but not in Africa, where the TB-MDGs will not be met without a major scale up in TB control efforts.

HIV is the biggest single challenge to TB control efforts on the continent. In several African countries, including those with well-organized control programs, the crisis of HIV/AIDS has caused such dramatic increases in TB cases that the annual number of reported TB cases has risen more than fivefold since the mid 1980s. HIV infection is now the most important predictor of TB incidence across the African continent. At the same time TB accelerates the progression of HIV to AIDS. In 2003 over 80% of the global total of deaths among TB-HIV co-infected patients were in Africa. The life expectancy of an HIV infected person with TB is measured in weeks if treatment is not available.

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Future projections are not optimistic. UNAIDS concluded that a fall in the numbers of HIV- infected people in Africa before 2010 is unlikely.² Currently, across the African continent 35% of TB cases are HIV-infected, although, in several African countries, these rates are much higher. For example, HIV levels in patients with TB in Namibia, South Africa and Zambia all stand at around 60% and in Botswana, the rate is 80%. This is compared to about 8% globally. As HIV rises, so the proportion of women diagnosed with TB increases, while their average age decreases.

In Bangkok in 2004 Nelson Mandela said "To fight against AIDS, we must do more to fight TB". So far this advice has largely gone unheeded, yet over half a million HIV infected people develop TB annually in Africa. They are also eligible for ART, and nearly 300,000 each year are already in contact with the health service. Thus, TB programmes are important entry points for ART scale-up. Availability of HIV testing and antiretroviral treatment in this population would help significantly towards reaching the goals of the US President's Emergency Plan for AIDS Relief notably those of treating two million HIV-infected people with antiretroviral drugs and providing care for ten million HIV-infected people.

TB is not only strongly linked to HIV, but also to poverty and the weak infrastructures and health systems that are its consequences. The low levels of economic performance in most African countries and the high levels of armed conflict and displacement of people create conditions of poor nutrition, crowding, and poor health service delivery that fuel transmission of the disease. In sub-Saharan Africa, it is estimated that only 53% of the population has access to health services. Even existing health systems and services are weak and sometimes poorly organised. In these, TB control will not succeed until the general health services, TB control program staff and other disease specific programs work together to address the basic priorities. But health sector reform must be carefully handled: priority setting at district level can sometimes exclude TB as a priority, and even compromise sound TB control activities, as in Zambia in the 1990s.

The lack of sufficient trained staff is consistently cited as the main constraint facing TB control. The quantity, competencies and distribution of staff are all important elements of an effective TB program. Health workers constitute the heart of the health services, yet in Sub Saharan Africa there is only about 1 health worker per 1000 population. The global average is 4, while it is 10.9 for North America. Time for planning, supervision and management is limited, and is all too often absorbed by uncoordinated missions of bilateral and multilateral funding agencies, and their technical counterparts. DOTS programs can do much more to engage the full range of health care providers (including all public providers, NGOs and private practitioners) as well as community members.

Multidrug-resistant tuberculosis (MDR-TB), although a serious threat to global TB control, is not yet a serious problem for TB control in most of Africa.

Despite considerable increases in the funding made available for TB control by the governments of the high TB incidence countries and of the donor countries, almost all African countries still face a shortfall in the funding needed to reach the global targets. Statements of political commitment by government leaders must be matched by concrete support in terms of increased funding. The Global Fund to fight AIDS, TB and Malaria is a significant innovative forward step, and will make a large contribution towards TB control if it can ensure rapid movement of the funding to where it can be used.

What then are the priorities?

In a nutshell, more resources still need to be mobilized for expanding the progress in the fight against TB; leaders everywhere, including in Africa, need to move from awareness to commitment and commitment to action; and a small amount of funds needs to be allocated specifically to support international technical assistance to countries for TB program design and monitoring.

First, unprecedented co-ordinated efforts by governments, donors, technical agencies and other stakeholders are urgently needed in Africa, in close collaboration with National TB and AIDS Control

Programs. Progress depends on raising the profile of TB on political and development agendas, and mobilizing increased political commitment and funding among African countries. Pan-African institutions such as the African Union and the New Partnership for African Development need to be more involved. TB is estimated to cause an economic loss of 4-7% of GDP annually in countries with a high burden of TB and the disease is closely linked to poverty. It ought therefore to be more often incorporated in Poverty Reduction Strategy Papers (PRSPs) and in debt relief arrangements for the Highly Indebted Poor Countries (HIPC).

Second, sub-Saharan Africa specifically requires increased support to strengthen its DOTS Programs. This requires increased staffing, specific measures to retain staff once recruited, and a huge increase in training. Full engagement of the entire range of health providers including the private and NGO sectors is important to increase access to DOTS. Regulatory and legislative reform may be necessary to ensure this can happen. Communities need also to be engaged, especially in rural areas, and other marginalized segments of society. The role of community members in provision of diagnostic and care delivery services needs to be developed.

Third, close collaboration is required between National TB and AIDS Control Programs to deliver joint TB/HIV activities, including provision of HIV testing to TB patients, provision of ARV treatment³ and screening for TB among HIV service clients. TB/HIV collaboration has a particularly large impact on reducing the mortality from TB.

Fourth, the resources available for TB control should be increased and sustained. The STOP TB Partnership is currently developing a second global plan, for the period 2006-2015, to achieve the MDG TB targets with the eventual aim of eliminating TB as a public health problem. Provisional cost estimates indicate that about \$30 billion USD, or an average of \$3 billion per year, will be required between 2006 and 2015 for global TB control activities to achieve the MDG TB targets. The DOTS strengthening and TB/HIV components alone would avert an additional 2.5 million new TB cases and 2.5 million TB deaths globally. Of this, nearly \$9 billion USD is required for Africa to avert an additional estimated 700,000 new TB cases and 1 million TB deaths. The current global funding gap for all countries is of the order of \$1 billion per year.

Fifth, relatively small amounts are needed to catalyze the work of new funding mechanisms such as the Global Fund, and enable their resources to flow more rapidly. There has been a massive request from countries for international technical assistance and support in planning and building capacity to implement TB control activities and monitor progress. However, there has been only a minimal increase in dedicated funding to help provide this complementary technical support to countries. Stop TB partners, including WHO, have had difficulty in responding to this overwhelming demand. The additional resources required for providing these international technical inputs to program design and monitoring have been estimated globally at approximately \$50 million per year, of which only \$25 million was available in 2004. Scaling up activities aimed at greater TB/HIV collaboration, increasing public and private sector involvement and other initiatives will further increase the need for technical support.

Sixth, because of the longer term gains promised, investment in research and development of new vaccines, drugs and diagnostic tools is also important, provided that research and development efforts address the specific needs of those who are HIV infected.

In conclusion, Africa is in desperate need of a significant scaling up of TB control efforts. It is technically feasible, lacking only the political commitment and the financial resources.

I thank you for your attention.

¹ World Health Organisation. Global Tuberculosis Control: Surveillance, Planning and Financing. Geneva, Switzerland, 2005. WHO/HTM/TB/2005.349

² UNAIDS. AIDS in Africa: three scenarios to 2015. UNAIDS, Geneva, Switzerland, 2005. UNAIDS /04.52E.

³ World Health Organisation. Interim Policy on Collaborative TB/HIV activities. WHO/HTM/TB/2004.330 and WHO/HTM/HIV/2004.1